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X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 18 1943

Registration District No. 23-5

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17527

Primary Registration District No. 3010

Registrar's No. 153.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days (Specify whether years, months or days)
In this community 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wayne
(c) City or town Shook - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 miles South of Shook, Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Mc Collister
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosie Mc Collister
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Feb (Month) 7 (Day) 1870 (Year)

8. AGE: Years 73 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Wayne Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name James Mc Collister
13. Birthplace Wayne Co. (City, town, or county) Mo. (State or foreign country)
14. Maiden name Nancy Cousort
15. Birthplace Wayne, Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs Nettie Barger
(b) Address Cape Girardeau, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Wayne Co. Mo.
18. (a) Signature of funeral director M. D. Lorberg
(b) Address Cape Girardeau Mo.
19. (a) 5-14-43 (Date received local registrar) (b) H. R. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1943 hour ____ minute 3:00 A.M.

21. I hereby certify that I attended the deceased from 5-11 1943 to 5-14 1943 that I last saw h[illegible] alive on 5-14-43 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Nephritis	
Due to	
Due to Hyp. Prostate	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature C. L. Dunn (M. D. or other) MD
Address Cape Girardeau Date signed 5-14-43

1014

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 64 3 - 23

Date Filed 6 - 7 - 43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed C. J. Loehrig

Licensed Embalmer No. 3810

P. O. Address Cape Girardeau, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 15-3

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Mc Collister
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 7 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days If less than one day hr. min.

9. Birthplace Wayne (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 14 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Nephritis (a)	
Due to Hyp. prostate	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 131 f	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature A. Burnett (M. D. or other) No
Address Cape Girardeau Date signed 6/11/43

SUPPLEMENTARY

No

17527